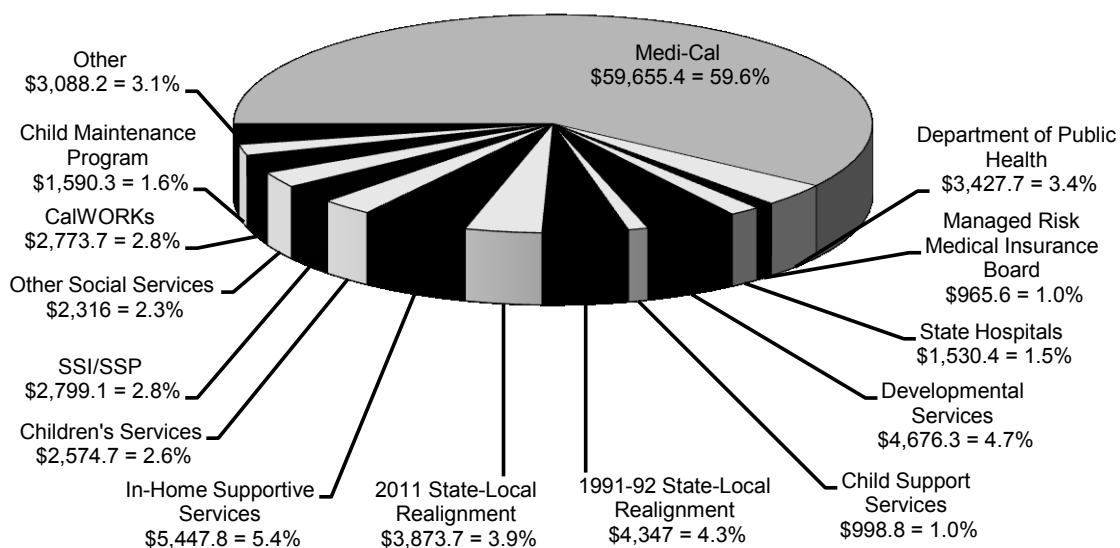


HEALTH AND HUMAN SERVICES

The Health and Human Services Agency oversees departments and other state entities, such as boards, commissions, councils, and offices that provide health and social services to California's vulnerable and at-risk residents. The Budget includes \$100.1 billion (\$26.4 billion General Fund and \$73.7 billion other funds) for these programs. Figure HHS-01 displays expenditures for each major program area and Figure HHS-02 displays program caseload.

Figure HHS-01
Health and Human Services Proposed 2012-13 Funding¹
All Funds
 (Dollars in Millions)



¹ Totals \$100,064.8 million for support, local assistance, and capital outlay. This figure includes reimbursements of \$9,108.5 million and excludes county funds that do not flow through the state budget.

Figure HHS-02
Major Health and Human Services Program Caseloads

	2011-12 Revised	2012-13 Estimate	Change
Medi-Cal enrollees	7,735,200	8,347,800	612,600
Healthy Families Program ^a	877,711	420,119	-457,592
California Children's Services (CCS) ^b	46,213	47,068	855
CalWORKs ^c	587,365	324,283	-263,082
Non cash-assistance CalFresh households	1,463,321	1,794,464	331,143
SSI/SSP	1,274,656	1,294,868	20,212
(support for aged, blind, and disabled)			
Child Welfare Services ^d	138,490	137,176	-1,314
Foster Care	46,810	42,363	-4,447
Child Maintenance ^c	0	296,132	296,132
Adoption Assistance	84,453	85,964	1,511
In-Home Supportive Services	433,839	422,993	-10,846
Community services for persons with developmental disabilities			
Regional Centers	249,827	256,059	6,232
State Hospitals			
Mental health patients ^e	6,320	6,439	119
Persons with developmental disabilities ^f	1,759	1,533	-226
Alcohol and Drug Programs ^g	304,312	337,025	32,713
Vocational Rehabilitation	28,203	28,203	0

^a Current year represents the year-end population. Budget year represents the remaining average monthly caseload not included in Medi-Cal.

^b Represents unduplicated quarterly caseload in the CCS Program. Does not include Medi-Cal CCS clients.

^c The Budget proposes a major restructuring of the CalWORKs program that, among other changes, limits the provision of employment services and child care to 24 months for families not fully meeting work participation requirements, and creates a separate Child Maintenance program to continue income support to children whose parents are not eligible for cash aid.

^d Represents Emergency Response, Family Maintenance, Family Reunification, and Permanent Placement service areas on a monthly basis. Due to transfers between each service area, cases may be reflected in more than one services area.

^e Represents the year-end population. Includes population at Vacaville and Salinas Valley Psychiatric Programs.

^f Represents average in-center population.

^g Represents Drug Medi-Cal Clients.

The Budget continues the efforts to streamline government operations to be more efficient and effective. The Budget provides the plan for completing the elimination of the Departments of Mental Health (DMH) and Alcohol and Drug Programs (DADP) and proposes several other reorganizations to improve efficiency and program delivery. Additionally, consistent with the Administration's goal of streamlining state operations as a result of 2011 Realignment, both DMH and DADP have reduced realigned program positions by at least 25 percent. The Department of Social Services (DSS) continues to develop its reduction plan associated with 2011 Realignment in concert with county actions relative to agency adoptions, how caseload growth will be addressed in the

pending realignment superstructure, and what the role of the Department will be regarding federal reporting, monitoring, and oversight of the realigned programs.

Significant Adjustments:

- The Budget reorganizes behavioral health programs. With the elimination of DMH and DADP, major community mental health programs and remaining non-Drug Medi-Cal programs and associated funding will be shifted to the Department of Health Care Services (DHCS). Co-locating these key mental health and substance use disorder services with physical health programs is the first step toward integrating services in preparation for an effective continuum of care, consistent with federal health care reform implementation in 2014.
- The Budget transfers a number of DMH and DADP programs to other state departments to better align the program's mission with that of the department. These transfers include: licensing functions to the Department of Public Health (DPH) and DSS; mental health workforce development programs to the Office of Statewide Health Planning and Development; the Early Mental Health Initiative to the Department of Education; problem gambling, driving under the influence, and licensing of narcotic treatment programs to DPH; and Mental Health Services Act technical assistance and training to the Mental Health Services Oversight and Accountability Commission.
- Transfer of the following medical services programs from DPH to DHCS effective July 1, 2012: (1) Every Woman Counts, (2) Prostate Cancer Treatment, and (3) Family Planning Access Care and Treatment. The transfer of these programs is consistent with the Administration's goal of placing direct health care service programs with the DHCS to improve service delivery.
- Consistent with the Administration's direction at May Revision, the Budget proposes the creation of the Department of State Hospitals, which is discussed in more detail later in this chapter.
- In preparation for California's implementation of federal health care reform, the Budget proposes the elimination of the Managed Risk Medical Insurance Board, which is discussed in more detail later in this chapter.

DEPARTMENT OF HEALTH CARE SERVICES

Medi-Cal, California's Medicaid program, is administered by DHCS. Medi-Cal is a public health insurance program that provides comprehensive health care services at low cost for low-income individuals including families with children, seniors, persons with disabilities, children in foster care, and pregnant women. The federal government mandates basic services including, but not limited to, physician services, family nurse practitioner services, nursing facility services, hospital inpatient and outpatient services, laboratory and radiology services, family planning, and early and periodic screening, diagnosis, and treatment services for children. In addition to these mandatory services, the state provides optional benefits such as outpatient drugs, home- and community-based waiver services designed to avoid institutionalization, and medical equipment, which avoid more costly services.

Medi-Cal costs have grown about 6 percent annually since 2006-07 due to a combination of health care cost inflation and caseload growth. Medi-Cal spending is projected to decline from \$15.4 billion General Fund in 2011-12 to \$15.1 billion General Fund in 2012-13 because of enacted and proposed program savings options. Absent these savings options, costs would grow by approximately 3.4 percent to \$15.9 billion General Fund.

Caseload will increase approximately 7.9 percent from 2011-12 to 2012-13 (from 7.7 million to 8.3 million), which is due primarily to shifting children in Healthy Families to Medi-Cal, which is discussed later in this chapter. Caseload growth would be 1.9 percent absent the proposal to shift children in Healthy Families to Medi-Cal.

Proposals to Balance the Budget:

Improved Care Coordination for Seniors and Disabled Beneficiaries. Within the Medi-Cal program, approximately 7 percent of beneficiaries account for 75 percent of program costs – mostly because of costly institutional services. These beneficiaries are typically seniors or persons with disabilities and they are frequently eligible for and enrolled in both the federal Medicare program and the Medi-Cal program. Approximately one-third of these individuals are also enrolled in the In-Home Supportive Services (IHSS) program. Individuals eligible for both Medi-Cal and Medicare are known as dual eligible beneficiaries. California has 1.2 million dual eligible beneficiaries, which represents 14.1 percent of the total Medi-Cal caseload. In addition, the majority of the 423,000 IHSS recipients (85 percent) are dual eligible beneficiaries. These dual eligible beneficiaries represent some of the most expensive and medically complicated health

cases and the cost for their care is paid by public funds, including federal funds, state General Fund, and in some cases county funds.

Medicare is the primary insurance/payer for dual eligible beneficiaries and covers medically necessary acute health services such as physician services, hospital services, and skilled nursing. Medi-Cal is the secondary insurance/payer and typically covers Medicare cost sharing and services not covered by Medicare, as well as services delivered after Medicare benefits have been exhausted. Most long-term care costs for these beneficiaries are paid for by Medi-Cal, including longer nursing home stays and home and community-based services designed to prevent institutionalization. In addition, many of these beneficiaries are also eligible for IHSS, which is locally administered and includes a county share of cost. Consequently, the current system attempts to address the health care needs of the most chronically ill and vulnerable beneficiaries through a variety of providers that receive funding from multiple government sources. The system is riddled with incentives that encourage payers to shift costs to one another.

The fractured funding streams and administrative responsibilities make it difficult for dual eligible beneficiaries to navigate program benefits associated with this uncoordinated fee-for-service environment. As a result, these individuals will benefit the most from a care model that provides benefits in a more coordinated manner. Coordinating care for these beneficiaries generally means having the same health plan responsible for the delivery of all benefits. This will achieve significant efficiencies and improve care for beneficiaries. This also will help beneficiaries remain in the community and reduce costs from unnecessary hospital and nursing home admissions. In addition to aligning program responsibility and financial incentives, this proposal increases the number of individuals in managed care and broadens the scope of managed care services. This proposal works to:

- **Promote Coordinated Care**—Managed care done properly results in high-quality care. This initiative provides managed care plans with a blended payment consisting of federal, state, and county funds and responsibility for delivering the full array of health and social services to dual eligible beneficiaries. The proposal combines strong beneficiary protections with centralized responsibility for the broader continuum of care. This combination will promote accountability and coordination, align financial incentives and improve care continuity across medical services, long-term services, and behavioral health services.
- **Enhance the Quality of Home and Community-Based Services**—Within an expanded system of coordinated care, it is critical to better coordinate medical services with

the full continuum of long-term services, including In-Home Supportive services, Community-Based Adult Services, and nursing home services. Merging long-term services into managed care will increase access to home and community-based medical and social services. Improving access to these services should help beneficiaries remain in their homes and out of institutions, and should improve their health outcomes. When necessary, care will also be coordinated with behavioral health services, which generally will be provided by counties. The Home and Community-Based Services Waiver for Persons with Developmental Disabilities will continue to be administered by the Department of Developmental Services.

The proposal to improve care coordination for dual eligible beneficiaries will be phased in over a three-year period starting January 1, 2013. The transition to managed care for Medi-Cal benefits will occur in the first year, with the benefits becoming a more integrated plan responsibility over the subsequent two years. The transition of Medicare benefits to managed care will occur over a three-year period starting first with eight to ten counties that already have the capacity to coordinate care for these individuals. Beneficiaries in counties in which Medi-Cal managed care plans may not yet have the capacity to take on additional beneficiaries will begin to transition six or twelve months later. The Budget separately proposes to expand Medi-Cal managed care statewide starting in June 2013. Beneficiaries in these managed care expansion counties will transition in 2014-15.

In year one, IHSS, other home and community-based services, and nursing home care funded by Medi-Cal will become managed care benefits. The IHSS program will essentially operate as it does today, except all authorized IHSS benefits will be included in managed care plan rates. Beneficiaries in the eight to ten selected counties will also receive their Medicare benefits and long-term services and supports through their Medi-Cal plan. This represents about 800,000 of the 1.2 million dual eligible beneficiaries currently in California. These changes will be phased-in over a 12-month period starting January 1, 2013. Over time, managed care plans will take on increasing responsibility for home and community-based services, including IHSS.

Delivering services through Medi-Cal managed care plans will make the state the single point of accountability for services to these beneficiaries. This will ensure access to the entire continuum of health care services for dual eligible beneficiaries through their Medi-Cal managed care plan. Delivering these services through Medi-Cal managed care plans, however, also raises important issues that will need to be considered in the program design including, but not limited to: (1) consumer protections for acute, long-term

care, and home and community-based services within managed care; (2) development of a uniform assessment tool for home and community-based services; and (3) consumer choice and protection when selecting their IHSS provider. The Administration will consult consumers and other stakeholders in this effort.

This proposal also sets the foundation for the state to implement health care reform, which further impacts the health care delivery and financing structure by expanding Medi-Cal to include all adults below 138 percent of the federal poverty level. In addition, it establishes the state as the level of government primarily responsible for delivering health care services. Additional issues to consider related to the state-county relationship in financing and delivering services include determining the collective bargaining structure for IHSS providers, and the long-term county financial responsibility for IHSS and other health care programs. The Administration will work with counties and stakeholders to address these overarching issues through the development of legislation that will be necessary to implement this Budget proposal.

As beneficiaries transition from fee-for-service to coordinated managed care, the state will generate savings due to a reduction in hospital and nursing home costs. However, because Medi-Cal is budgeted on a cash basis, there is a delay in realizing these savings. To accelerate these savings into 2012-13, the Budget also proposes a payment deferral (one payment for all providers), and alignment of payment policies for all managed care counties. Together, this proposal will achieve savings of approximately \$678.8 million General Fund in 2012-13 and \$1 billion General Fund in 2013-14.

Medi-Cal: Operational Flexibilities. Medi-Cal is a major health care delivery system approaching an enrollment of 8.3 million Californians and is estimated to gain another 2 million beneficiaries when federal health care reform is implemented in January 2014. The Medi-Cal health care delivery system must have the capacity to respond to the rapidly changing field of health care and be able to change benefits, services, rate methodologies and payment policies faster than the current regulatory process allows. Examples of potential program changes include reducing laboratory rates, no longer funding avoidable hospital admissions, and no longer paying for services of limited value.

The Budget proposes a process that will incorporate stakeholder input and determine cost-effectiveness before implementing changes in benefit design, and includes a post-implementation assessment to ensure that changes achieve the intended results. Similarly, any changes in rate methodologies and payment policies driven by this process

will comply with federal requirements to rigorously monitor the impact of rate changes on beneficiary access to services and to mitigate any problems as they arise. Under the proposed process, the Medi-Cal program will have the flexibility it needs to operate a health care delivery system that meets its obligations to use sound evidence, transparent processes, and monitoring mechanisms to ensure the program achieves its outcomes in the most efficient possible manner.

This proposal will achieve General Fund savings of approximately \$75 million in 2012-13 and ongoing.

Federally Qualified Health Center Payment Reform. The Budget proposes to reform the payment methodology for federally qualified health centers (FQHCs) and rural health clinics (RHCs) funded under Medi-Cal to create a performance, risk-based payment model that will allow, and reward, these clinics to provide more efficient and better care. Under this proposal, payments made to FQHCs and RHCs participating in Medi-Cal managed care plan contracts will change from a cost and volume-based payment to a fixed payment to provide a broad range of services to its enrollees. A waiver of current operating restrictions will empower FQHCs to follow efficient best practices, such as group visits, telehealth, and telephonic disease management. The waiver will ensure that medical care is provided by the most appropriate and affordable medical professional and allow clinics to perform multiple services on the same day. The efficiencies will allow these community health centers to provide better and more efficient care, and to expand capacity. The proposal will achieve General Fund savings of \$27.8 million in 2012-13 and \$58.1 million in 2013-14.

Managed Care Expansion. Beginning in June 2012, the Budget proposes to expand managed care into rural counties that are now fee-for-service only. This expansion will provide beneficiaries throughout the state with care through an organized delivery system. This proposal will result in a General Fund savings of \$2.7 million in 2012-13 and \$8.8 million in 2013-14.

Annual Open Enrollment. Current law authorizes Medi-Cal beneficiaries to change plans once per month or up to 12 times in a year. The Budget proposes an annual open enrollment period for beneficiaries to select their Medi-Cal health plan and receive care through that health plan for the entire year. This open enrollment process will align Medi-Cal with industry best practice of other third-party health benefit payers including CalPERS and Healthy Families. By establishing an annual election process, plans will be accountable for providing beneficiaries with a medical home, care coordination,

and case management over the entire year leading to better care and health outcomes. This proposal will achieve General Fund savings of \$3.6 million in 2012-13 and \$6 million in 2013-14.

Medical Therapy Program Eligibility. The Budget proposes to align income eligibility requirements for the Medical Therapy Program with the broader California Children's Services (CCS) Program. Currently, there is no financial test for eligibility. Under the proposed eligibility standards, families with annual income less than \$40,000 or with annual CCS-related medical expenses exceeding 20 percent of their annual income will continue to be eligible for the Medical Therapy Program. This is consistent with the eligibility requirements already in place for all other CCS benefits and will result in savings of \$9.1 million General Fund in 2012-13 and \$10.9 million in 2013-14. In addition to state savings, counties will also realize savings.

Stabilization Funds. The Budget proposes a one-time redirection of private and non-designated public hospital stabilization funding that has not yet been paid for fiscal years 2005-06 through 2009-10 to provide General Fund savings and avoid direct service reductions. This proposal will achieve one-time savings of \$42.9 million General Fund.

Gross Premium Tax. The Budget proposes to eliminate the sunset date of the Gross Premiums Tax on Medi-Cal managed care plans. Continuing the tax, coupled with increased managed care utilization, will generate General Fund savings of \$161.8 million in 2012-13 and \$259.1 million in 2013-14.

Other Significant Adjustments:

- **Medi-Cal Base Benefit Costs**—A decrease of \$395.9 million General Fund in 2011-12 and an increase of \$493.9 million General Fund in 2012-13 based on cost and utilization trends in the base program.
- **Budget Savings Erosions**—An increase of \$778.2 million General Fund in 2011-12 and \$235.3 million General Fund in 2012-13 because of delayed federal approval of budget savings proposals, litigation related to elimination of the Adult Day Health Care benefit, and a portion of the provider payment reductions not being approved by the federal government.
- **Hospital Fee Extension**—A savings of \$255 million General Fund in 2011-12 and \$472 million General Fund in 2012-13 as a result of extending the hospital fee.

The fee provides funds for supplemental payments to hospitals and also makes some funding available to offset the costs of health care coverage for children.

- **Managed Care Rate Adjustment**—An increase of \$203.4 million General Fund in 2012-13 as a result of increasing managed care rates by 3.61 percent. Rate adjustments are based on the previous year's increase. The managed care rate adjustments for 2012-13 will be updated in May 2012.
- **Nursing Home Fee Program**—The Budget includes funding to restore the 10-percent provider rate reduction (\$171.2 million General Fund) and also includes supplemental payments (\$245.6 million General Fund). The Budget does not include the maximum 2.4-percent cumulative rate increase for 2011-12 and 2012-13 because preliminary fee revenues are insufficient to support such an increase. The Budget also proposes to permanently extend the rate methodology and nursing home fee initially established by Chapter 875, Statutes of 2004 (AB 1629). This extension is necessary to continue to fund the current payment methodology without a greater impact to the General Fund.
- **Reserve for Litigation**—The Budget includes a set-aside of \$86.8 million General Fund in 2011-12 and \$260.4 million General Fund in 2012-13 in the event litigation challenging recently approved provider rate reductions is successful.

MANAGED RISK MEDICAL INSURANCE BOARD

The Managed Risk Medical Insurance Board (the Board) administers five programs that provide health coverage through commercial health plans, local initiatives and county organized health systems to certain persons who do not have health insurance. The five programs include:

- The Access for Infants and Mothers Program, which provides comprehensive health care to pregnant women.
- The Healthy Families Program, which provides comprehensive health, dental, and vision benefits through participating health plans for children who are not eligible for Medi-Cal.
- The County Health Initiative Matching Fund Program, which provides comprehensive benefits similar to the Healthy Families Program, but through county-sponsored insurance programs.

- The Major Risk Medical Insurance Program (MRMIP), a state-funded program, which provides health coverage to residents of the state who are unable to secure adequate coverage for themselves and their dependents because insurers consider them to be medically uninsurable or at high risk of needing costly care.
- The Pre-Existing Conditions Insurance Plan (PCIP) Program, a federally funded program which provides health coverage to medically uninsurable individuals with pre-existing conditions. The program is only available for individuals who did not have health coverage in the six months prior to applying.

The Budget includes \$965.6 million (\$136.2 million General Fund) for the Board, a decrease of \$152.4 million General Fund from the Budget Act of 2011. This significant decrease is primarily due to the proposed Healthy Families rate reduction.

Proposal to Balance the Budget:

- Healthy Families Program Rate Reduction—The Budget proposes to reduce Healthy Families managed care rates by 25.7 percent effective October 1, 2012. This rate reduction will achieve General Fund savings of approximately \$64.4 million in 2012-13 and \$91.5 million in 2013-14.

Other Significant Adjustments:

- Transition of Children from the Healthy Families Program to Medi-Cal—The Budget proposes transferring approximately 875,000 Healthy Families Program beneficiaries to Medi-Cal over a nine-month period beginning in October 2012. This transition will create benefits for children, families, health plans, and providers, by: (1) simplifying eligibility and coverage for children and families; (2) improving coverage through retroactive benefits, increased access to vaccines, and expanded mental health coverage; and (3) eliminating premiums for lower-income beneficiaries.
- Transition of Other Programs—In preparation for California's implementation of federal health care reform, the Budget proposes to eliminate the Board by July 1, 2013. Therefore, the remaining programs administered by the Board will transition to the DHCS by July 1, 2013. These programs include the Access for Infants and Mothers, California Health Initiative Matching Fund Program, MRMIP, and PCIP programs. The two programs that provide insurance to individuals with pre-existing conditions, MRMIP and PCIP, will be eliminated in January 2014 because these individuals will be able to purchase health insurance through the California Health Benefits Exchange as part of federal health care reform implementation.

DEPARTMENT OF PUBLIC HEALTH

The DPH is charged with protecting and promoting the health status of Californians through programs and policies that use population-wide interventions. Funding for 2011-12 is \$3.5 billion (\$132.4 million General Fund), and proposed funding for 2012-13 is \$3.4 billion (\$124.8 million General Fund).

Proposal to Balance the Budget:

- Increase Client Share of Costs for the AIDS Drug Assistance Program (ADAP)—The Budget reflects a decrease of \$14.5 million in 2012-13 as a result of increasing client share of cost in the ADAP to the maximum percentages allowable under federal law. Cost-sharing for ADAP clients with private insurance will be limited to a maximum cost-sharing of two percent. Implementing the federal share of cost maximum amounts for this client group will create a disincentive for many clients to continue ADAP participation because their cost-sharing obligation will exceed their private insurance out-of-pocket costs. This proposal will result in General Fund savings of \$16.5 million, which will be offset by program administrative costs of \$2 million for a net General Fund savings of \$14.5 million. Average monthly copayments will range between \$28 and \$385, depending upon the client's income.

DEPARTMENT OF DEVELOPMENTAL SERVICES

The Department of Developmental Services (DDS) serves approximately 256,000 individuals with developmental disabilities in the community and 1,500 individuals in state-operated facilities. Proposed funding for 2012-13 is \$4.7 billion (\$2.7 billion General Fund). Services are provided through the developmental centers, one community facility, and the regional center system. The Lanterman Developmental Disabilities Services Act established a statewide network of regional centers and related services to allow consumers to live independent and productive lives in the community.

Significant Adjustments:

- Program Reductions—A decrease of \$200 million in 2012-13 as a result of the reductions related to lower-than-expected revenues assumed in the 2011 Budget Act. To achieve these savings, with the intent of minimizing the impact on consumer services, the DDS is considering extending the 4.25-percent provider and regional center operations payment reduction, reductions in the developmental

center budget, and other potential savings options in the department's budget. DDS will be engaging stakeholders to discuss savings proposals.

- **Developmental Centers**—A decrease of \$14.4 million General Fund (\$724,000 Proposition 98 General Fund) in 2012-13 as a result of a revised population estimate.
- **Reduced Costs**—A decrease of \$32 million General Fund in 2011-12 and a decrease of \$2.9 million General Fund in 2012-13 as a result of changes and delayed implementation of Medi-Cal savings proposals regarding the Adult Day Health Care program, caps, and copayments, which will delay the need for regional centers to backfill these reductions.
- **Regional Center Caseload Adjustment**—An increase of \$5.9 million General Fund in 2011-12 and an increase of \$115.2 million General Fund in 2012-13 as a result of a revised population estimate.
- **Expiration of Provider and Regional Center Operations Payment Reduction**—An increase of \$108.4 million General Fund in 2012-13 as a result of the 4.25-percent provider and regional center operations payment reduction expiring on June 30, 2012.
- **Proposition 10**—An increase of \$50 million General Fund in 2012-13 to backfill for the one-time use of Proposition 10 funding for services to consumers age 0-5 years.

DEPARTMENT OF STATE HOSPITALS

To create an efficient system of care focusing on effective treatment and increased worker and patient safety, the Budget establishes a new Department of State Hospitals (DSH). State hospitals operated by the DSH provide long-term care and services to individuals with mental illness. The state supports patients committed by the courts, including those committed for Penal Code violations and Sexually Violent Predators. Counties fund civil commitments. The Budget includes \$1.3 billion General Fund in 2012-13 for support of the Department. The patient population is projected to reach a total of 6,439 in 2012-13. The Department will provide efficient and appropriate care and treatment for patients, a safer environment for individuals and fiscal responsibility and transparency.

Developing the new DSH resulted in a thorough evaluation of the state hospital system and its budget. The evaluation highlighted unfunded activities within the system, some of which were the result of federal court orders. In December 2011, a report was released

that focused on the issues to be addressed by the DSH, and proposed a plan to address a current year funding shortfall of approximately \$180 million. Through a combination of current year cost-saving measures, the shortfall was reduced to approximately \$63 million. The Budget reflects ongoing savings of \$193.1 million and 620 positions through staffing ratio changes, program flexibilities, and other efficiencies. Additional aspects of the plan include:

- Streamlined Services and Operational Efficiencies—Based on experience implementing the state hospital Enhancement Plan, DSH will modify the Plan to reduce documentation, implement flexible treatment models, and eliminate ineffective auxiliary services. This will allow level of care staff to return to providing treatment services, allow hospitals to make treatment decisions that are most appropriate for the individuals in their facilities, and reduce the need for additional staffing.
- Stronger Fiscal Accountability—The new DSH structure supports enhanced communication between hospital and headquarters staff, and consolidates fiscal operations to ensure consistent information sharing among budget, accounting, and operations staff.
- Staffing Ratio Adjustment—A decrease of \$21.3 million General Fund in 2011-12 and a decrease of \$68.7 million General Fund in 2012-13 as a result of changes to the staffing ratios of physicians and treatment teams and changes to the staffing mix of registered nurses and psychiatric technicians.
- Program Restructuring/Elimination—A decrease of \$8.6 million General Fund in 2011-12 and a decrease of \$24.4 million General Fund in 2012-13 as a result of modifications to services and treatments and elimination of less effective programs within the hospitals.
- Pharmaceuticals and Outside Medical Costs Adjustment—A decrease of \$2 million General Fund in 2011-12 and \$23 million General Fund in 2012-13 as a result of the availability of generic drugs and revisions to contract rates.
- County Bed Rate Adjustment—A decrease of \$20 million General Fund in 2012-13 as a result of increased bed rates charged to counties for civil commitments to more accurately reflect actual patient cost of care.
- Staff Redirection Adjustment—A decrease of \$8.4 million General Fund in 2011-12 and a decrease of \$15.4 million General Fund in 2012-13 as a result of redirecting staff to higher priority assignments and reducing overtime and temporary help costs.

- Streamlined Documentation—A decrease of \$6.9 million General Fund in 2011-12 and a decrease of \$14 million General Fund in 2012-13 as a result of modifications to documentation processes.
- Elimination of Funding for Caregiver Resource Centers—A decrease of \$2.9 million General Fund in 2012-13 as a result of eliminating contract funding for Caregiver Resource Centers, which provide services to individuals with acquired brain disorders.

In addition to changes related to the new DSH, the Budget reflects ongoing court-ordered commitments to treat CDCR inmates with mental health needs, including an increase of \$39.4 million and 368.1 positions for *Coleman* court-ordered patient care and the activation of the new Stockton health care facility, as noted in the following adjustments.

Other Significant Adjustments:

- Reorganization—A decrease of \$119.9 million (\$15 million Proposition 98 General Fund and \$593,000 General Fund) in 2012-13, and a corresponding increase in various department budgets as a result of the elimination of the DMH.
- Overtime and Temporary Help Adjustment—An increase of \$102.4 million General Fund in 2011-12 and 2012-13 as a result of increased workload associated with enhanced patient observations, admissions assessments, and redirected staff to comply with the Civil Rights of Institutionalized Persons Act.
- Operating Expenses and Equipment—An increase of \$45.1 million General Fund in 2011-12 and 2012-13 as a result of the increased cost of pharmaceuticals and outside medical care.
- Population Adjustment—An increase of \$13.9 million General Fund in 2011-12 and \$44.3 million General Fund in 2012-13 as a result of the anticipated population increase primarily related to the court-ordered increase in *Coleman* patient admissions.
- Safety and Security—An increase of \$22.8 million General Fund in 2012-13 to fund new alarm systems at Patton and Metropolitan State Hospitals, pending the successful implementation of a similar system at Napa State Hospital. In addition, the DSH is piloting an Enhanced Treatment Unit at Atascadero State Hospital and working with the Division of Occupational Safety and Health to institute new safety policies and procedures throughout the state hospital system.
- California Health Care Facility—An increase of \$11.4 million General Fund in 2012-13 as a result of the anticipated opening of the facility in July 2013.

DEPARTMENT OF SOCIAL SERVICES

The DSS administers programs that provide services and assistance payments to needy and vulnerable children and adults in ways that strengthen and preserve families, encourage personal responsibility, and foster independence.

The Budget includes \$17.5 billion (\$6.2 billion General Fund), a decrease of \$2.3 billion General Fund from the Budget Act of 2011. This significant decrease primarily is due to reflecting savings associated with 2011 Realignment within the appropriate DSS programs. These savings were reflected in a statewide item in the 2011 Budget Act rather than in individual department budgets.

CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS

The CalWORKs program is California's version of the federal Temporary Assistance for Needy Families (TANF) program. For low-income families with children, the program provides temporary cash assistance to meet basic needs and welfare-to-work services so that families may become self-sufficient. The program recognizes the different needs in each county and affords them flexibility in program design and funding.

After many consecutive years of decline in caseload, the CalWORKs program has experienced significant growth in recent years due to the severe economic downturn. Absent the program changes described below, the average monthly caseload in this program is estimated to be 597,000 families in 2012-13, a 0.5-percent increase from the 2011 Budget Act projection. This represents almost a 30-percent increase compared to the low point of 460,000 cases in 2006-07. The proposed changes to CalWORKs are estimated to reduce the 2012-13 caseload projection to 324,000 families, a 44.8-percent decrease from the 2011-12 estimate after accounting for cases transferred into the new Child Maintenance program.

Prior to CalWORKs, the state administered the Aid to Families with Dependent Children (AFDC) program, which provided cash assistance to needy families regardless of whether or not recipients were working. California's AFDC program caseload peaked at 921,000 cases in 1994-95. The state also operated the Greater Avenues to Independence employment program which, because of limited funding, only served a small portion of adults receiving aid. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 fundamentally reformed the nation's welfare system and included provisions to convert the AFDC entitlement program to TANF, a block grant program with work requirements and lifetime time limits.

Effective January 1, 1998, CalWORKs replaced the AFDC program. Consistent with the federal welfare reform law, CalWORKs contains time limits on the receipt of aid and linked eligibility for aided adults to work participation requirements. As part of CalWORKs, the state included a safety net program to provide monthly assistance payments to children whose parents are not eligible for aid. In 2005, the federal welfare reform was modified to further restrict countable work activities and to require states to have 50 percent of the program's caseload meeting federal work participation levels.

In the early years of CalWORKs, counties were successful in getting many of the most readily employable CalWORKs families to enter the labor market. This was evidenced by the substantial decline in the welfare caseload, which decreased from a high of 921,000 cases in 1994-95 to an all-time low of 460,000 cases in 2006-07. Subsequently, with the steep rise in national and state unemployment stemming from the recession, the caseload has increased and its composition has changed. A significant share of the caseload has not been subject to work participation requirements. This is in addition to the portion of caseload that is required to participate in work activities but is not doing so. Over time, the safety net and child only caseload has become larger than the caseload that is subject to work requirements. Additionally, because of severe budget constraints, recent grant and earned income disregard reductions, as well as cuts to employment and child care services described later, have further reduced the "work first/work pays" goals of the program. Major programmatic changes are necessary to refocus the work emphasis of the program in light of both the composition of the current CalWORKs caseload and the state's limited resources.

Absent any changes, General Fund costs in CalWORKs are projected to grow by more than half a billion dollars in 2012-13 compared to the 2011 Budget Act. The primary drivers of this increase are expiration of "short-term reforms" and an increased caseload projection. The short-term reforms, which have been included in the Budget on a one-time basis each year since 2009-10, have achieved savings through a significant reduction in the amount of funding made available to counties to provide employment services and child care to CalWORKs recipients. Families with a child between the ages of 12 and 23 months, or with two or more children under the age of six, have been exempt from work requirements. Over time, these short-term reforms have significantly eroded the work focus of the CalWORKs program, prevented assistance to needy clients on a path to success, and left the state more vulnerable to costly federal work participation penalties.

Proposal to Balance the Budget:

Redesigning and Refocusing the CalWORKs Program. The CalWORKs program is a “work first” program that encourages employment as the most direct method of achieving self-sufficiency. With the impacts of the Great Recession still lingering, the changes described below are necessary to refocus the CalWORKs program to prioritize resources on the families most likely to become employed and to manage the program within the state’s available resources. The new strategy creates two subprograms within CalWORKs, each with differing grant structures, services arrays, and time limits:

- **CalWORKs Basic Program.** The CalWORKs Basic program will serve families moving toward self-sufficiency by providing up to 24 months of welfare-to-work services, including job search, employment training, child care, and barrier removal services (e.g., substance abuse, mental health, and domestic violence recovery assistance). Effective October 2012, clients not participating in sufficient hours of unsubsidized employment after an initial job search will be placed in the CalWORKs Basic program and will be required to participate in welfare-to-work activities. After the first 12 months, the adult will again participate in job search. If, during the second 12 months, the adult remains unable to find unsubsidized employment, the adult will continue to participate in welfare-to-work activities, including subsidized job placements. As in the current program, failure to meet welfare-to-work requirements will result in a sanction equal to the adult portion of the grant. Clients unable to meet federal work participation requirements after 24 months, or cases in sanction status for more than three months, will be disenrolled from CalWORKs.
- **CalWORKs Plus Program.** The CalWORKs Plus program will serve those clients working sufficient hours in unsubsidized employment to meet federal work participation requirements, generally 30 hours per week (20 hours per week for families with children under the age of six). Effective April 2013, this program will reward clients who meet federal work participation requirements with a higher grant level by allowing them to retain more of their earned income through a higher income disregard (first \$200 earned and 50 percent of subsequent income disregarded for purposes of computing the monthly grant level). For a family of three, this equates to an average increase of \$44 per month. These clients will also have full access to supportive services and child care. These benefits will continue for up to 48 months as long as clients continue to meet work participation requirements through unsubsidized employment. After 48 months, the adult will no

longer be aided, but the higher earned income disregard will remain available if the employment continues.

This new design will use incentives to encourage unsubsidized employment and focus available resources on early client engagement. State and federal rules regarding hours of required participation will be aligned. This, combined with eliminating current state rules regarding core and non-core work activities, will afford counties maximum flexibility under federal law. Sanction months will count toward the 48-month time limit, further emphasizing the importance of work. As a package, the proposal will save the CalWORKs program \$1.1 billion in 2012-13.

Transition to Success. To assist families in obtaining employment sufficient to meet federal work participation requirements, all currently aided eligible adults will be eligible for up to six months of welfare-to-work services and child care following the October 2012 implementation of the CalWORKs Basic program. Prior to this transition, \$35.6 million will be provided to counties to serve these families.

Providing Additional Work Supports. Consistent with the proposal to redesign and refocus the CalWORKs program, the Administration proposes to align eligibility and need criteria for low-income working family child care services with federal TANF rules for work participation requirements. Over time, the three-stage child care system for current and former CalWORKs recipients and programs serving low-income working parents will be replaced with a work-based child care system administered by county welfare departments. (Refer to “Reduce Child Care Costs and Restructure Administration of Child Care” in the K-12 Education chapter for more information.) In addition, the Administration proposes to create a state benefit to increase support for low-income working families. Beginning July 1, 2013, the state will provide working families receiving CalFresh benefits or child care, but who are not in the CalWORKs program, with a \$50-per-month supplemental work bonus. Providing this additional benefit to working families will increase the state’s work participation rate and help avoid federal TANF penalties.

CHILD MAINTENANCE PROGRAM

The Budget provides continued support to children from low-income families. Beginning in October 2012, the state will create a new Child Maintenance program to provide for child well-being through basic support to children whose parents are not eligible for aid under the restructured CalWORKs program. Income and resource eligibility criteria for the Child Maintenance program will be the same as for CalWORKs families, but the

Child Maintenance program grant will be less than the current amounts available for child-only cases. This will decrease the average monthly grant for child-only cases from \$463 to \$392. When combined with CalFresh benefits, the full monthly grant will be sufficient to keep families of three with CalFresh-eligible adults at approximately 64 percent of the federal poverty level. Children will be aided as long as they meet eligibility criteria, including a new requirement to participate in an annual well-child exam. There are estimated to be 296,000 Child Maintenance cases on average each month in 2012-13.

Because Child Maintenance cases are outside of the state's welfare-to-work program, they will have minimal case management and an annual reporting requirement. These cases can move to the CalWORKs Plus program anytime by obtaining unsubsidized employment sufficient to meet federal work participation requirements. Every six months, work-eligible adults who still have time remaining on the 48-month aid clock may ask for one month of child care to attend job search. If a sanctioned adult still has time remaining on the 48-month aid clock and the 24-month services clock, the family can transfer to the CalWORKs Basic program after complying with a welfare-to-work plan for at least two months. The cost of this program partially offsets the savings in CalWORKs, resulting in a net savings of \$946.2 million.

IN-HOME SUPPORTIVE SERVICES

The In-Home Supportive Services (IHSS) program provides domestic services such as housework, transportation, and personal care services to eligible low-income aged, blind, and disabled persons. These services are provided to assist individuals to remain safely in their homes and prevent institutionalization.

The Budget proposes \$1.4 billion General Fund for the IHSS program in 2012-13, a decrease of \$292.3 million General Fund from the revised 2011-12 IHSS budget. General Fund costs are significantly higher in the revised current year projection than in the 2011 Budget Act primarily because of erosions to savings previously assumed. Specifically, General Fund costs of \$231 million result from a six-month delay in extending the state sales tax to IHSS providers, a two-month delay in implementing the Community First Choice Option for enhanced federal funding, a two-month delay in eliminating services for recipients without health care certification, and from not implementing the medication dispensing machines proposal. Additionally, an increase of \$130 million accounts for savings from program integrity efforts already being captured in the caseload projections. The average monthly caseload in this program is estimated to be 423,000 recipients in 2012-13, a 2.5-percent decrease from the 2011-12 projected level.

Proposals to Balance the Budget:

Eliminate Domestic and Related Services for Certain Recipients. Domestic and related services include housework, shopping for food, meal preparation and cleanup, laundry, and other shopping and errands. Currently, when an IHSS beneficiary resides in a shared living arrangement and his/her need for any domestic or related service is met by other household members, the authorized hours are pro-rated by county social workers based on the number of household members. Under this proposal, IHSS beneficiaries residing in a shared living arrangement will not be eligible for domestic and related services that can be met in common with other household members. In instances where the shared living arrangement consists entirely of IHSS recipients, domestic and related services will continue to be authorized. In addition, IHSS beneficiaries who have a need for domestic and/or related services that cannot be met in common because of a medically verified condition of other members of the shared living arrangement can be authorized hours for any of these services that meet the need assessment metrics. Similarly, when minor recipients are living with their parent(s), the need is being met in common; hence, the authorization of domestic and related service hours will no longer be allowed. Since minors would not be expected to be able to perform these services independently, the parent will be presumed available to perform these tasks unless the parent can provide medical verification of his/her inability to do so.

Eliminating domestic and related services for recipients in shared living arrangements and minor recipients living with an able and available parent is estimated to provide General Fund savings of \$163.8 million in 2012-13 and is estimated to impact approximately 254,000 recipients beginning July 1, 2012.

Coordinated Care for Dual Eligible Beneficiaries. This proposal will better coordinate IHSS, other home and community-based services, and institutional long-term care. All individuals receiving both Medi-Cal and Medicare benefits (dual eligible beneficiaries) will be required to enroll in managed care health plans for their Medi-Cal benefits. The IHSS program will operate as it does today during 2012-13; all authorized IHSS benefits will be included in managed care plans. No IHSS savings are estimated to result from this proposal in 2012-13. Refer to “Improved Care Coordination for Seniors and Disabled Beneficiaries” within Department of Health Care Services for more information.

Other Significant Adjustments:

- 20-Percent Reduction in Service Hours—Because revised revenue projections have fallen short of previous estimates, pursuant to Chapter 41, Statutes of 2011,

a 20-percent across-the-board reduction in IHSS hours was to be implemented January 1, 2012. Because of a court injunction, the state currently is prevented from implementing this reduction. However, the Budget assumes this reduction will be implemented April 1, 2012. To be prudent, the Budget also includes a set-aside to fully fund the IHSS program in the event of an adverse court ruling.

- Medication Dispensing Machine Pilot Project—Current law requires the state to implement a Home and Community Based Medication Dispensing Machine Pilot Project that utilizes an automated medication dispensing machine with associated telephonic reporting service for monitoring and assisting Medi-Cal recipients with taking prescribed medications. Current law also requires the DSS to implement an across-the-board reduction in authorized hours for IHSS recipients beginning October 1, 2012, to the extent the pilot project and/or alternative savings proposals enacted by the Legislature does not achieve a combined net annual General Fund savings of \$140 million. Based on the assumed 20-percent reduction described above, the Budget assumes neither savings from the pilot project nor savings from the associated across-the-board reduction, and proposes to repeal the associated statutory requirements.

DEPARTMENT OF CHILD SUPPORT SERVICES

The Department of Child Support Services (DCSS) is designated as the single state agency responsible for administering the statewide child support program. The Budget includes \$998.8 million (\$313.2 million General Fund) for the DCSS, a decrease of \$7.2 million General Fund from the revised 2011-12 Budget and a decrease of \$8.4 million General Fund from the 2011 Budget Act.

CHILD SUPPORT COLLECTIONS

The child support program establishes and enforces orders for child, spousal, and medical support from absent parents on behalf of dependent children and their caretakers. For display purposes, the Budget reflects the total collections received, including payments to families and collections made in California on behalf of other states. The General Fund share of assistance collections is included in statewide revenue projections. The General Fund portion of child support collections is estimated to be \$253.7 million in 2011-12 and \$263.6 million in 2012-13. The increased General Fund collections in 2012-13 primarily reflect the continued suspension of the county share of collections.

Proposal to Balance the Budget:

Suspend County Share of Collections. The Budget proposes to suspend the county share of child support collections in 2012-13. The county share of collections is estimated to be \$34.5 million in 2012-13. Under this proposal, the entire non-federal portion of child support collections will benefit the General Fund on a one-time basis. This will not reduce the revenue stabilization funding of \$18.7 million (\$6.4 million General Fund) counties receive for caseworker staff in order to maintain child support collections.